DOCUMENT RESUME

ED 308 444 CG 021 769

AUTHOR	Neider, John R.; And Others
TITLE	Refugees and the State Mental Health Systems: Issues and Impacts.
INSTITUTION	Minnesota Univ., Minneapolis. Refugees Assistance Program - Mental Health Technical Assistance Center.
SPONS AGENCY	National Inst. of Mental Health (DHHS), Rockville, MD.
PUB DATE	5 Apr 88
CONTRACT	NIMH-278-85-0024-CH
NOTE	19p.
AVAILABLE FROM	Refugee Assistance Program--Mental Health Technical Assistance Center, University of Minnesota, Box 85, Mayo, Minneapolis, MN 55455.
PUB TYPE	Viewpoints (120)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Locus of Control; *Mental Health Programs; Program Design; *Program Development; *Program Effectiveness; Psychiatric Services; *Psychological Services; *Refugees; Regional Cooperation; Resource Allocation; *State Agencies
IDENTIFIERS	Refugee Assistance; *Refugee Mental Health

ABSTRACT

This paper examines critical issues for states and advocacy groups in trying to develop short-term goals to address mental health needs of refugees and to plan long-term strategies for state and county service systems for this population. The paper begins with a discussion of the following issues: (1) centralized versus decentralized state mental health systems; (2) specialized versus mainstream programs; and (3) locus of control in state and county mental health systems. This is followed by a discussion of the characteristics and distribution of the refugee population from state to state, the varying state approaches to resource allocation, and the emergence of coalitions of various ethnic groups. The remaining sections discuss the scale of the overall service system and its resources within states, new potential funding resources, and regional coordination of resources. References are included. (TE)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED308444

Refugees and the State Mental Health Systems: Issues and Impacts

Prepared for the National Institute of Mental Health
Refugee Assistance Program - Mental Health: Technical Assistance Center
University of Minnesota
Contract No. 278 85 0024 CH
Santa Fe, New Mexico, Working Group on Refugee Mental Health, March, 1988

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Amos S. Deinard

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CG 021769

John R. Neider B.A.
Thom Bornemann Ed.D.
Peter W. Van Arsdale Ph.D.
April, 5, 1988

BEST COPY AVAILABLE

INTRODUCTION

This paper describes some of the factors that influence the development of a mental health care system for refugees. This specific group has been generally ignored in planning both at the state and national level. The RAP and TAC initiatives were developed in response to the states requests for assistance and expressed needs in developing responsive programs for the mental health needs of refugees.

While this country has a long history of immigration, the recent influx of refugees has severely taxed existing mental health programs. This is partly due to the history of such refugees. Many of them have experienced decades of war and forced relocation in their country of origin. These people have already been refugees for years before ever leaving their country of origin. Additionally, some of them have been incarcerated in concentration camps, reeducation camps and prisons. Torture, chronic malnutrition, loss of family, are common histories with these refugees. Moreover, prolonged stays in refugee camps rife with sickness, malnutrition, and social problems, have increased the refugees' liability. Clearly this group presents in the country of final refugee with a very different background from those European immigrants that have traditionally come to the United States. These forced migrants often present in their new country of refuge with problems in multiple areas. Many existing state and local programs have not known how to deal with these groups and have oftentimes ignored their needs. The NIMH/ORR initiatives have attempted to examine this problem and outline some

approaches that can be used to target the refugee population in a culturally appropriate fashion.

This paper examines the systems issues that are critical to the states in trying to a) develop short-term goals to address mental health needs of refugees (i.e. development of programs) and b) plan long-term strategies that will have continuing impact on state and county service systems. Listed below are some of the issues that must be considered from both the administrative and clinical perspectives:

1. Centralized versus Decentralized State Mental Health Systems
2. Specialized versus Mainstream Programs
3. Locus of Control
   a. Decision makers (formal and informal) within state mental health organizational structure
   b. Decision points within county mental health organizational structure
4. Characteristics of refugee population
   a. Number and type of ethnic groups
   b. Distribution of refugee groups
   c. Influence of ethnic groups/coalitions
5. Scale of mental health system, existing resources
6. New funding resources
7. Regionalizaion of resources
   a. County
   b. State
   c. Regional

The above list highlights a series of concerns that are important to the planner in making meaningful decisions regarding refugees and the state mental health system.

Discussion

1. Centralized versus decentralized mental health systems. With the advent of block grant funding, the states assumed greater control and decision making in how resources were distributed. Community Mental Health Agencies, clinics and programs previously had received more direction from the federal government. However, with the change in direction shifted to the states, they had the responsibility for determining how funds are distributed. Establishing priorities within the states for access to funds became very competitive and many states elected to spend such monies for programs that did not necessarily address the needs of special populations. As a consequence, after a decade of such competition, refugee groups have been left without the necessary and appropriate resources within the mental health system.

Nationwide, the states themselves currently tend to model a heterogeneous mix of centralized versus decentralized mental health systems. States such as California and Texas strongly resemble the national model, wherein counties within the state have substantial control over the development and distribution of resources without

much intervention by the state government. At the other end of the continuum are states such Minnesota, Virginia and Colorado which take stronger, more centralized control of such development by mandating through various regulations and state laws the manner in which counties are to address special issues that the state deems important. Sometimes this may include underserved populations (i.e. gay population, ethnic population-- native peoples, Blacks, Hispanics, Asians--, women) or it may include groups defined by various conditions (i.e. IV drug abusers, HIV positive, homeless, single parents, Amerasian children and handicapped). While it is not unusual for the national government to target one or more of these groups as needing special attention by the states, sometimes accompanied by special funding, often however, it is left to the states to make the appropriate programming and funding decisions based on their assessment of the need. Partly this is the result of a slow developmental process and delayed recognition of need by both the states and the Federal government. While some early target programs may have been appropriate to the refugee population, over time certain other needs, particularly in mental health, have become apparent and demand attention.

The application of this rough model to the RAP and other refugee mental health initiatives suggests that within the state mental health agency, appropriate pathways should be pursued in line with these criteria. In states such as Colorado with centralized bureaucratic control of mental health directives, greater efforts should be focused through the director's office. Conversely, states with decentralized systems such as California should pursue

program development and funding through counties based upon need and resources.

Centralized models have pathways and decision-making points that are less geographically disparate. Effort can be localized within state capitols and lobbying can be accomplished with greater ease. However, within such systems, problems can develop if designated providers prove to be unreliable. If states pursue centralized resource allocation approaches, i.e. development of refugee service centers , and such centers are improperly managed and staffed, then refugees have no other options for care. Refugees become more "service vulnerable". To achieve the appropriate resource development to target the needs of refugees, certain of the lobbying and advocacy efforts should be service center-specific. It is also critical that close communications be maintained between the Commissioner's office and such centers.

Decentralized states with varying refugee population densities can theoretically have counties respond effectively to specific needs. However, while such systems can be more responsive to local needs, counties may not have appropriate resources to address such needs. And given the state organization, it may be difficult for a single county to command adequate resources from the state to target high-risk refugee clients. Practically, efforts must be made at both the local county level and state levels to encourage allocation of resources to specific counties which demonstrate "targeted need." These efforts can take the form of lobbying with county mental health officials as well as state level mental office bureaus. The RAP program can arrange meetings between providers

at the local county level and planners at the county level as well as at the state level. Allocation of funds can be redirected via new needs assessment that has the capability of estimating the utilization of mental health services by such groups as refugees. Meinhardt and Vega have worked in this area, developing a tool that helps counties estimate the need for mental health services by specific ethnic groups (Meinhardt and Vega, 1987). This tool, developed by Warheit et.al., uses a low cost method, telephone surveys, to assess mental health needs and allows planners to make equitable adjustments to bring underserved groups into the service delivery system (Warheit et. al., 1983).

One specific problem that develops in states with decentralized systems is in areas of the state with smaller populations of refugees. Given one of the most important criteria for resource allocation--population density--such counties cannot command monies to address the needs of such small groups. This, of course, does not obviate the need, but it can mean that creative solutions must be sought to address this specific problem.

One such attempt in California has resulted in a proposal for the development of a team of "mobile experts." These experts would have extensive experience in assessment and treatment of cross cultural problems. They might be based in one county with a high population of refugees, but could travel to a specific location in an adjacent county and consult with problem cases that have appeared within the local county. These cases might have surfaced within a local medical facility or through the courts. On the other hand, this team of experts could also be sent on a regular basis to a pre-

arranged, central location where the assessment can take place in a facility with appropriate resources to completely work up such cases. (Oftentimes such cases require additional testing and workups beyond the initial interview and it is useful to have all such resources at one site.)

Clearly there are inherent problems in this approach that remain unanswered. On the surface these teams might seem a quick answer to an immediate resource crisis, however, over the long term--if service priorities change--such teams may prove no more than band-aid solutions to the problem of continuing treatment and assessment. Long term goals might be to use these groups in other ways, such as continuing education, training professionals and paraprofessionals in cross cultural mental health service.

In addition to the problems already discussed there exists an additional set of problems that cannot be ignored or separated from the mental health area. These are acculturational problems and attacking one set of problems (i.e. mental health) on an intermittent basis may not allow another set to be addressed adequately. Assessment and treatment of such clients needs to integrate the resources, both mental health as well as acculturative in trying to help such clients. Sending patients out from their area of residence for service does not allow for such integration.

The case of Florida is illustrative for different reasons. A large number of Cubans immigrated to Florida in the 1960's. This largely educated and vocationally trained group did not make great demands on the welfare system and over the years acquired political power, wealth and highly skilled jobs. However, the Mariel boatlift brought

a qualitatively different population of Cubans to Florida. These people tended to be much less educated than the the former group of Cuban refugees; some of them had histories of mental illness or criminal behaviors. This group had a severe impact on the service delivery system in Florida, an effect which eventually reached the national level. It triggered the establishment of several regional centers around the United States to attend to initial placement and assessment needs of these Cubans, as well as a system for the relocation of some of them to other parts of the country. The state was unable to establish adequate service for these later Cubans and subsequently the Mariel group overloaded the state system. The Federal government recognized these problems and in 1980 established a treatment center at St. Elizabeth's Hospital in Washington, D.C.

This case offers a model wherein service delivery was created in response to an immediate crisis that was a result of national policy (i.e. willingness of U.S. to accept entrants and refugees from third world countries) yet was impacting local governing units such as the state and county. These same states and counties, severely impacted by the influx of refugees from Asia, Central and South America and the Caribbean, who have minimal mental health resources to care for these groups, might benefit from a stronger national presence in allocating resources for these problems.

2. Specialized versus mainstream clinical programs. The need for specialized versus mainstream mental health programs cannot be evaluated apart from the other variables already mentioned. Part of

the decision to pursue one approach over the other is dictated by the state level administrative framework, distribution of the refugee population, scale of the system, and available resources. Separate or specialized programming initiatives have been espoused by administrators, anxious to demonstrate that they are attending to the specific needs of a particular lobby or group. In the 1970's there was a proliferation of programs dedicated to working with Native peoples, Hispanics, women, gays, handicapped, elderly, single parents, etc. The covert message was that these people could not, for various reasons, have their needs met by mainstream service delivery systems. Whether a result of intentional bias, inadequate training and inability to understand or account for sexual or cultural differences in prospective clients, negative stereotypes ensued. Conversely there were advantages to the specialized programs set apart from the mainstream clinics. They could more easily attract clients who might wish to be seen in a more hospitable environment and by professionals perhaps more tolerant of their individual differences. Sometimes funds could be attracted more easily to such programs, based upon a rationale that programs staffed by people with the same characteristics as the clients would have better success in helping them. (This has long been the belief in many traditional substance abuse treatment programs, where recovering para-professionals are considered the sine qua non.)

Important problems remain with such approaches. The volume of client activity is critical for survival and the rise and fall of such "set-apart", specialized programs is highly situation-specific; they are very vulnerable to political exigencies and short-term

legislative changes. Their funding is often short-term and their staffs must often struggle with having to balance service to the client with the need to obtain more funding. Their effort can be diluted as they try to balance clinical duties with administrative duties. Speciality clinics sometimes rely on bilingual staff who are not otherwise fully trained to handle the complex clinical and administrative problems. Finally, as larger administrative units perception of existing problems change, they may unilaterally remove funding for such programs. Frequently there may be a lack of professional support for such set apart programs. Moreover, a professional bias can grow from such an administrative plan as paraprofessionals are left on their own yet are criticized for their lack of training or professional direction.

Conversely, some mainstream facilities rely appropriately upon specialized programs, the advantages for such an arrangement include improved resource management, economy of scale when larger programs have more resources to allocate, enhanced professional direction and supervision, can serve a larger population, cross fertilization occurs among staff and the clinic has a broader foundation to address the needs of a specialized program. Indeed, culturally appropriate mainstreaming need not be defined as "staffing a mainstream facility with trained bilinguals", but rather as "systematized mainstream-speciality links, aided by culturally specific staff training" (Colorado RAP-MH, 1987). Decisions on which mainstreaming paths to pursue for both RAP and non-RAP states require assessment of current resources within the state in question. The authors of this paper suggest that mainstream

programming which is partially reliant upon specialized modules or clinics would have greater longevity and experience less fluctuation from funding pressures.

3. Locus of control. This is important to understand when attempting to effect change within existing systems. Both decision points and decision makers (formal and informal) must be identified. If particular states follow the decentralized model then focal points at the state level (i.e. commissioner's office) will not always be initially useful; these likely can be assigned second-level priority. In these states short-term strategies would suggest the pursuit of contacts at the county level, or through regional centers. These might include state hospitals or community mental health centers. However, long-term strategies demand that larger networks be tapped or expanded to deal with the problems of refugees in the areas of acculturation and mental health. Coordination is the modal activity in states with decentralized mental health services particularly at the state level in the directors office and the county mental health office.

While it might be the case that the mental health service delivery system has a high degree of local autonomy, the state refugee coordinators office may control allocation of funding for other efforts regarding refugees, especially social service and employment. Coordination of effort, identification of decision points within states, and constant open communication is necessary in order to organize efforts that will produce both short- and long-term changes. While the RAP coordinator might be successful on the

local level in establishing a clinic or specialized program for mental health service, it will not have much success unless linked inter-systemically with other refugee resources and programs. Both the Refugee Coordinator and Department of Mental Health need to be talking about areas of mutual collaboration. The RAP coordinator can be linking these two groups together to assess levels of cooperation, e.g. the refugee office does a needs assessment and the Mental Health Department might include several questions to help determine service delivery needs.

4. The characteristics of the refugee population. These are also critical factors in helping define the particular path to pursue regarding short/long term goals. The types of refugee groups (ethnicity, refugee experience, country of origin experience) will effect the particular plan regarding allocation of existing resources and future planning. In many states the refugee population is largely Southeast Asian. Other states, such as California, Texas, and Florida, because of the geographical position of these states, also have sizeable populations of Hispanic refugees (legal-status and otherwise), Cubans, Central and South Americans.

Oftentimes there is a tendency to emphasize one ethnic group's particular needs over another. One strategy is to advocate for general refugee mental health services. An even broader approach has been promulgated by Virginia with the establishment of an Office of Cross Cultural Services, that broadens the net to include refugees and other immigrants. There is value to this approach in that resources do not become designated for one particular class or

type of immigrant. Also it is useful in obtaining funding resources from a variety of sources (Office of Cross Cultural Services, 1988). Criticisms of this approach include, diffusion of effort and resources and support might be limited to special interest groups.

When the population is widely distributed throughout state, it is difficult to have an even distribution of resources and effort. States such as Minnesota, while having refugees throughout the state, the sizeable populations occur in mainly the metropolitan areas, (Minneapolis-St.Paul, Duluth, Rochester, Fairbault). As suggested earlier, geographical distribution of the refugee population plays a major role in determining service delivery priorities. Agency effort can be focused--or dissipated--accordingly. In Minnesota the region from Rochester north to the Twin Cities geographically spans only 100 miles. Yet, more than three-quarters of the refugee population lies in this corridor. Resources can be consolidated and concentrated accordingly. However, in areas such as California, which has the largest number of refugees, the population is widely dispersed, with pockets of high concentration (Asian Community Mental Health Services, 1987). Other states that are more rural, such as Iowa and Wisconsin, while having some urban populations of refugees, also have isolated pockets of refugees in rural areas where resources are scarce. In these states attention might focus on settlement policies, detailing the problem of directing refugees to isolated, rural areas for initial placement. In terms of resource allocation, the options are generally to transport client to central locations for care.

While we have focused on state agencies and institutional sites as sources of official decision making, the local Mutual Assistance Associations can serve as important advocates for change. Some of these groups have bonded together in consortiums to gain visibility around issues of social adjustment and mental health. Often such coalitions can achieve some change within existing systems. The difficulty has been to get disparate ethnic groups to agree on common agendas. Dr. Yang Sam in Philadelphia has had some success in this endeavor, linking together Cambodians, Hmong and Vietnamese to achieve a larger coalition. Ethnic lobbies, by coordinating effort, also can be effective in obtaining visibility and commanding resources. (Sometimes efforts in this area can fail, such as The International Refugee Center of Colorado which was less successful.) Unfortunately, the current system of resource allocation works against this method. MAA's are encouraged to submit competing proposals for the limited funds available. This divided effort is not an effective way for Mutual Assistance Associations to achieve sustained change within the system.

5. Scale of system. Finally, the scale of the overall service system and its resources within a state, will be critical to the refugee mental health specialists. States with small- to moderate-sized refugee populations, linked to centralized systems as discussed earlier, may find it easier to effect improved mental health services for refugees. Advocacy groups can help redirect attention and priorities among the various state agencies dealing with refugees and mental health. In this situation, the RAP office

would be a coordinator of effort among these groups or coalitions to help set agendas and establish plan of direction. The key actors at the state level would include the Director of Mental Health , Director of Refugee Services, and Director of Social Services Office. By bringing them together and exploring resources that could be utilized to help plan equitable service delivery, the RAP office can redirect efforts to underserved refugee populations.

6. New funding resources. New resources are critical to the continuation of current programs and initiatives. While much has been accomplished through RAP initiatives, much more remains to be done. The current success of any effort may well vanish without continued monitoring, program resource development and advocacy. The RAP mandate includes finding alternate sources of funding to continue efforts around mental health programming and systems development. Sources include private foundations, state agencies, as well as agencies such as NIMH, NIAAA, NIDA, and NIH. An example of how monies might be leveraged are Rhode Island and Colorado who have used needs assessment data to modify current contracting policies to redistribute allocation of funds for refugee mental health services.

7. Regionalization of resources. This is one strategy for some states to pursue. Geographically contiguous states who have large number of refugees may be able to agree on coordination of resources. One state might set up a special facility or program to

work with substance abusers; another state might focus on a long-term residential site that would be appropriate for cases involving chronic illness such as schizophrenia. Yet another state may target initial assessment, with particular emphasis upon areas such as neuropsychological and forensic evaluations. This might involve a designated team as the California RAP program has suggested, that would be available on an inter-state contract basis among states.

Summary

The above discussion is meant to highlight some of the critical factors that are necessary as RAP and other personnel review plans for specific initiatives and program development as well as the coordination of disparate agencies and groups to focus upon common goals. This effort can be more productive if the above issues are factored into any planning process with particular attention being paid to issues of resource allocation and resource leveraging--enabling programs to extend well into the future.

References

1. Meinhardt K, Vega W: A Method for Estimating Underutilization of Mental Heal Services by Ethnic Groups. Hospital and Community Psychiatry 38:1186-1190, 1987.

2. Warheit GJ, Vega WA, Buhl-Auth J: Mental health needs assessment approaches: case for applied epidemiology. Prevention and Human Services 2:9-34, 1983.

3. Colorado RAP-MH The Colorado Refugee Mental Health Needs Assessment: Project Summary , Colorado Division of Mental Health, 1987.

4. Office of Cross Cultural Services Vantage Point: Quarterly Newsletter of the Office of Cross Cultural Services. Winter Issue. Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

5. Asian Community Mental Health Services The California Southeast Asian Mental Health Needs Assessment. California State Department of Mental Health.